This is an author accepted manuscript version of 'Response to Gender bias in medical education: stop treating it is an inevitability'

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We welcome the feedback (1) and dialogue about our study (2). We will clarify our perspective and its ontological, epistemological and axiological underpinnings. We concur about the perils of a cisnormative worldview and the imperative for gender diversity in medical education as evinced by our earlier commentary (3). Our participants identified exclusively as male or female (2), therefore it was untenable to relate their narratives more broadly to people who are transgender, non-binary gender or gender fluid.

Some of our findings (2) may be construed as indicating overt gender bias, but they were not viewed as such by the participants. Our study (2) raises questions about what *"counts"* as gender bias to medical students, as the participants set out the circumstances which might make them more or less inclined to challenge inappropriate behaviour in relation to this issue. Therefore, it was of cardinal importance to discuss the circumstances, conditions and factors that may result in some medical students being socialised to normalise gendered ways of learning. The emphasis in our study (2) was not on reporting systems and the obligations of medical schools. This does not absolve medical schools of their obligations to ensure gender parity and to have effective reporting systems. Instead, our study (2) underscores the pressing need for more effective measures to address gender bias in medical education in light of its deleterious impact on individuals and patient safety (3).

Top down approaches are important, but they are not a panacea and there are no proven solutions to gender bias in medical education. Medical schools must take urgent action informed by research, theory and dialogue to ensure gender parity in medicine. Bias is often subtly manifest in behaviour such as othering, healthcare systems are complex (3), and gender is socio-culturally constructed (2). Gender intersects with other aspects of identity that can give rise to prejudice such as ethnicity, sexual orientation, class, and religious belief (4). Meaningful change arises when things are understood as they are experienced, and people have a theory of action that reflects their reality (5). Education only emancipates, empowers, and liberates the oppressed when students and educators collectively develop theories to underpin learning in practice through dialogue as a community (6). It may be more apt to create communities of practice where students and educators work collaboratively in dialogical partnership to develop a shared culture of meaning which embeds gender equity in medical education.

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